Methods of Payment for Physicians' Services in Medical Care Programs*

FRANZ GOLDMANN, M.D., F.A.P.H.A.

Associate Professor of Medical Care, Harvard University School of Public Health, Boston, Mass.

THE PROBLEM

ADEQUATE remuneration of participating physicians is one of the prerequisites for effective operation of a medical care program furnishing direct service and, especially, for maintenance of high standards. Whether such a program is established and administered by a public agency or voluntary organization, whether the funds for its support are raised through general taxation, compulsory insurance, or voluntary insurance, systematic arrangements for payment for physicians' services must be made by negotiation and conclusion of more or less formal agreements between the administrative agency and the medical profession.

The participating physician expects, and is entitled to, a compensation recognizing the long period of professional education, the experience and skill acquired after graduation, the value of his service to both the individual and the community, the time and effort spent on his work, and the occupational hazards of practice. The agency administering the program must assure quantitatively and qualitatively adequate service at the least cost consistent with high standards, and balance the total expenditures for physicians' services with the total funds available for this type of care or for a variety of professional and institutional services.

It is anything but easy to reconcile the justified financial demands of the physicians with the obligation of an agency administering the people's money, whether it be tax funds or insurance contributions. The problem grows more complicated with increase in the total number of both persons eligible for and physicians participating in limited service programs. It becomes highly involved when the majority of the population of a country is covered by one or several comprehensive service programs and maintenance—or improvement—of the economic status of physicians as a group becomes a matter of public concern.

Quite understandably both form and amount of payment will be the subjects of disputes not only between administrative agencies and medical associations but between general physicians and specialists and between various specialists. If a proposal could be discussed strictly on the basis of technical considerations satisfactory solutions could be found without too much difficulty. Such an approach would be futile more often than not. Psychological factors are likely to exercise a paramount influence on the final decision. Fear of the new, of encroachment on their rights, of loss of prestige, of limitation of financial success or of the "entering wedge" induces many physicians to be opposed to any but the traditional fee-for-service method. "Les médecins veulent que la médicine conserve ses bases traditionelles, professionelles et sociales." In a

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score of tongues similar declarations have been made time and again. Bad experience sometimes leads physicians to condemn a method possessing intrinsic value because it has been discredited by poor organization, blundering and stultifying administration or malodorous politics. If a program of public medical care or of compulsory medical care insurance is involved, negotiations may be complicated by distrust of government that may be regarded much like a suspicious character, to be watched carefully or be presumed to be inefficient, if not ready to sacrifice a noble profession on the altar of politics.

BASIC METHODS

The search for the best method of paying physicians for service under organized programs of medical care has been protracted and intensive in every civilized country. It still continues. Three basic methods have been tried out in the course of centuries: the fee-for-service method, the flat-rate method, and the salary method. All have certain elements in common. They provide for payment for any of the services covered by a program, thereby opening up an important source of income for the physician and reducing the amount of free service and bad debts so often experienced in medical practice. They relate the remuneration of the physician to factors other than the economic conditions of the sick at the time he requests service, in contrast to the sliding scale that makes the *doctor medicinae* a tax collector, taking from his rich patients to give free or low-cost service to the poor. Each of the basic methods possesses distinctive attributes. Each has advantages and disadvantages that must be carefully weighed with due consideration to the circumstances prevailing in a given country, region, or locality.

In evaluating and comparing the financial arrangements, attention must be given to the rate as well as the form of payment, the effect on the type, quality, and quantity of service as well as the time and total professional income of the physician, and to the administrative implications. Comparative studies covering all these points are lacking. Those which have been made have been limited to some factors, particularly the costs.

Publications on the subject are legion, but many are confusing rather than enlightening. The terminology used by agencies and writers is far from uniform and often too vague to permit correct interpretation and valid conclusions. The opinions on the merits of the three methods are sharply divided and often diametrically opposed. It is therefore imperative to define the characteristics of each method as clearly as possible and to know the main arguments advanced for and against it. It should be borne in mind that some of the statements have never been substantiated by scientific investigation. Others have long been disproved by experience but nevertheless reappear regularly and blossom forth like perennials under loving care.

FEE-FOR-SERVICE METHOD

The fee-for-service method is characterized by three qualities. Payment is based on the type, number, and value of services actually rendered, standard fees or maximum fees are set for each type of service and published in a special fee schedule for a particular program or a generally valid official fee schedule, and the fees are uniform and binding for all participating physicians practising in a certain geographic area or rendering service under a given program. In general the fees are somewhat lower than those ordinarily charged in view of the fact that payment is certain, while collections in other practice usually represent only a certain proportion of the charges. The amount of income which the physician receives is influenced by both the number and kinds of service actually

rendered and the size of the fees.

Adoption of such a system involves determination of the numerous items of service to be included in the fee schedule, assignment of a price to each item, and formulation of rules and regulations concerning the use and interpretation of the fee schedule, the procedures to be followed in submitting bills, and the control of expenditures. Its effective and economical operation depends on the regular and prompt submission of accurate, itemized bills by the physicians and at least the review and audit of each bill and the regular payment of each account by the administrative agency.

In many countries the fee-for-service method is preferred by the physicians and will be readily accepted by them because it is the very system to which they are accustomed by tradition. In the opinion of its advocates it is better suited to the needs and wishes of all than any other method of payment. It affords not only compensation in proportion to effort—taking at least partial account of the work actually done—but wide opportunity to adjust the fees to the value of the services. Moreover, it provides an incentive to give the best care to the patients and thereby serves to strengthen the bond of sympathy and interest between patients and physicians.

The critics of this method point to a number of disadvantages. The system may have merits if only treatment of selected conditions is included in a program, but it is too difficult to operate and too expensive if the scope of service is comprehensive, including preventive as well as therapeutic services and care by specialists as well as general physicians. The emphasis is placed on "the number of acts done" rather than quality, and upon treatment of disease rather than conservation of health. The highly skilled physician is penalized because the fee schedule is too rigid to offer a reward for work requiring special knowledge and experience. The method hinders early referral of the patient to specialists and encourages excessive treatment, unnecessary service, especially surgical operations, or the use of expensive therapeutic procedures, such as injections, because the physician may be guided by fear of losing his patient to a competitor, by the desire to "hold the good will of the patient," or by financial considerations.

It burdens the physician with much paper work—the very thing he hates—and requires a complicated, cumbersome and costly machinery for its administration. Administrative control by authorization and reauthorization of specific services, reviewing and adjusting of bills, or both is inevitable in order to prevent soaring costs with their detrimental effect on the total budget or other services of the program. It may well happen that the payments to the doctor must be scaled down. What the physician finally receives is a product of two administrative procedures, the approval of his own bill and the reconciliation of all approved bills with the available funds. At best, it is what he has claimed and at the worst it is a fraction of his claim. If different programs in the same locality have fee schedules allowing different charges for the same type of service, dissatisfaction and unrest among the medical profession are inevitable.

FLAT-RATE METHOD

The generic term flat-rate method denotes a variety of specific forms of payment that are alike in two respects: fixed amounts of money are paid regularly and the rates represent average payments that are not related to the number of services actually rendered to the individual patient. The principle of averaging rests on the assumptions that some of the persons covered by a program will require little service and others much and that the total compensation will be in proportion to the total amount of work for all patients.

The basis for determination of flat rates may be (1) the unit of time, taking into account the number of hours, half days or full days actually worked by the physician, regardless of the number of patients seen; (2) the clinic session, taking into account the number of sessions actually held, without regard to the exact number of hours worked or the number of patients examined or treated; (3) the case of sickness or maternity, taking into account the number of cases actually attended, regardless of the type and amount of services rendered; or (4) the number of persons who have chosen the physician for a specified period of time, taking into account the number of persons eligible for service rather than that of the sick, irrespective of the type and volume of services rendered or the amount of time spent. The income of the physician depends on the size of the rate of compensation as well as the extent to which his services are utilized.

In the opinion of its advocates the flat-rate method has advantages outweighing its admitted disadvantages. If amount, scale and range of the compensation are adequate the method stimulates professional competition rather than financial competition. It provides an incentive to prevent illness and treat patients promptly, thoroughly, and economically, as the remuneration remains the same, whether a person is healthy or sick, whether the patient requires much or little service. The physician can rely on a regular and predictable income and is relieved of burdensome paper work, as no itemized bills are necessary. The administrative agency can estimate the probable expenses with a fair degree of accuracy and operate economically, because both computation of amounts payable and control of expenditures involve little in the way of administrative costs. However, the principle of averaging the remuneration is of limited applicability if the system of individual practice of medicine is combined with the method of paying flat rates according to the number of eligible persons or cases of illness.

Under this type of organization the flat-rate method can easily be employed for the compensation of general physicians because of the uniformity and predictability of the basic types of care, but it is not practicable for remuneration of specialists because of the diversity and unpredictability of their services. Quite different is the situation if flat rates are paid to group practice units. Under such an arrangement the organizations receive payment in proportion to the total number of persons who have chosen the group, and the staff members distribute the income according to their own wishes in the form of fees, flat rates, salaries, or a combination of these bases and in amounts determined by more or less formal agreements. This procedure permits recognition of both competence and effort. The potential dangers of relating payment to the number of persons on a physician's list or to the number of cases of sickness attended can be averted by limiting the number of persons or patients to be accepted by a physician or by allowing a higher rate for the first 1,000 persons or cases and progressively declining rates thereafter.

The opponents of the flat-rate method either deny the validity of the arguments advanced by the proponents or question the possibility of making an interesting theory work. Their objections are directed primarily against payment of flat rates according to the number of persons on the individual physician's list or the number of cases of sickness attended by physicians in individual practice. They contend that a limited amount of payment for unlimited service is a temptation to give a little service to many patients hastily and superficially ("rush medicine"), to do indifferent, careless, or inferior work, or to refer as many patients as possible to other physicians,

particularly specialists, or to clinics or hospitals for continued treatment. Thus, the quality of medical care will deteriorate, consistency of service will become a mockery, the time and skill of specialists will be requested unnecessarily and excessively, and the total costs of the program may well increase.

The conscientious physician giving freely of his time or the highly experienced physician performing superior service is certain to lose because he will be overworked and underpaid, while the less scrupulous and less skilled is likely to gain. If only the general physicians are paid flat rates and specialists are compensated on the basis of another method, a host of problems is created. The difficulty of defining the two groups may be overcome but profound disagreement over the wisdom of distinguishing between general physicians and specialists rather than between general physician's services and specialist services will prevent a satisfactory solution of the problem. Combination of the flat-rate method for general physician's services with the fee-for-service method for specialist service requires administrative control procedures greatly reducing the possibility of cutting down administrative expenses. Limitation of the work of the physician by placing ceilings on the number of patients or potential patients frequently is considered an infringement on the right to practise.

SALARY METHOD

The salary method is distinguished from the two others by the fact that fixed rates of compensation are paid periodically, usually every month, for performance of certain duties by the physician, regardless of the number of healthy or sick persons seen or the number of services rendered. Salaries are paid for part-time or full-time service and often represent net income. The rates are usually set for a year and their size is determined on the basis of qualification, experience, and age and, often also, of length of service under a given program. The total income of the physician depends on the amount of time he devotes to service under a program, his professional status and skill, the salary scale, and the type and amount of additional provisions known as "fringe benefits."

The proponents of this method argue that a guaranteed annual income commensurate with the duties to be performed frees the physician from the necessity of chasing after the elusive dollar and of the temptation to undertake more than he can master or to accept financial advantages for the referral of patients. The physician can devote his whole energy to professional work rather than spending precious time on financial statements, collaborate with his colleagues without fear of losing patients, and keep abreast of scientific progress without sacrificing income. Price competition is eliminated and quality competition encouraged, with resultant high standards of service. Administratively the method is advantageous because it involves no review, audit, and payment of countless different bills and thereby affords considerable savings.

The full-time salary method is opposed on many grounds that stem from the fear the physician would "sell the soul of his ideals for a mess of financial pottage" and lose his liberty for all time. A monthly salary check would kill the spirit of adventure, initiative, and freedom to act and all incentive to be interested in the patient, with the result of grudging response to calls, indifferent or superficial service, and low quality of care. The personal relationship between patient and physician would be undermined, if not destroyed. Appointments and promotions would be made on political grounds. Instead of being servants of the patients, the physicians would be servants of the program, "regimented

units of a system of bureaucratic control," compelled to perform their work at the pleasure of the administration officials and ending up as shabbily treated and underpaid "jobholders."

SUPPLEMENTAL PAYMENTS BY PATIENTS

Regardless of the method employed for the compensation of physicians, a service program may pay for the full cost of the standard services or for a definite proportion only. Full payment by the program implies that the patient is required to pay only for services desired for his special comfort and convenience, that he must not offer "extra" payment for any of the services covered, and that the physician must neither demand nor accept money in addition to the compensation allowed by the program. Under the system of partial payment by the program the patient may be required to make supplemental payments to the attending physician for specified services according to regulations, or the physician may be authorized to make additional charges with or without obligation to observe limits set in official fee schedules.

Full payment by the program, in the opinion of its advocates, enables the patient or potential patient to heed the advice "see your doctor early before he has to see you" and thereby encourages preventive measures, early diagnosis, and prompt and thorough treatment. It protects the sick against unpredictable, annoying, and possibly burdensome additional expenses and removes the temptation for the physician to raise his charges on the grounds that part of the cost will be paid by the program. It preserves the principle of service in contrast to the principle of indemnification for expenses actually incurred.

Those favoring supplemental payments by patients argue that such a policy prevents abuse of the services and excessive demands on the time of the physician. Without "deterrents" patients would "run to the doctor for every sneeze, sniffle, and headache." The obligation to contribute to the cost at the time service is demanded fosters a sense of responsibility and keeps the total cost of the program within reasonable limits.

Between the extremists there is a school of thought advocating full payment by the program for all "necessary" professional services at the office, clinic, and hospital; and partial payment for home visits in general or under particular conditions, for drugs and appliances other than those declared "essential," and for materials needed for certain diagnostic and therapeutic procedures.

PRESENT PATTERNS

The extent to which the three basic methods have been employed in the past and the frequency of their utilization at present vary not only from country to country but from one section of the same country to the other and from one type of program to the other in the same geographic area. A few examples will serve to show the diversity of patterns in some democratic countries.

In the United States the majority of all physicians rendering direct service under the various programs of medical care are compensated on the basis of the fee-for-service method, the part-time salary method, or the flat-rate method, in this order of frequency, and the minority hold full-time salaried positions. In Great Britain, where all but a small number of physicians are participating in the National Health Service, most of the "general practitioners" are paid flat rates per person on their lists and all specialists receive salaries for part-time or full-time work under the program of public medical care. In Denmark, where practically all physicians render service under the functionally coördinated extensive systems of public medical care and compulsory

insurance against sickness costs, the large majority of all general physicians receive fixed annual amounts for every person on their lists and supplementary fees for certain services, such as night calls; most specialists hold full-time salaried positions in hospitals; and a small minority of general physicians and specialists are paid on the basis of the fee-for-service method. In Norway, where almost all physicians participate in the large-scale system of compulsory sickness insurance operated in conjunction with extensive provisions for public medical care, the physicians who are not on the staff of a hospital bill the insured patients according to an official fee schedule and the insured is reimbursed for the larger part of the cost, while most specialists are paid salaries for part-time or full-time work in hospitals. In Sweden, where a broad system of public medical care is supplemented by subsidized voluntary insurance plans covering general physicians' services, the majority of all general physicians derive the bulk of their income from salaries paid by public agencies for part-time work and from fees allowed by the voluntary insurance organizations. Almost all specialists are full-time or part-time members of salaried hospital staffs.

The variations in the utilization of the basic methods under identical conditions as well as different types of programs in the same country are strikingly exemplified by the situation in the United States. The fee-for-service method is generally employed by certain tax-supported programs, such as the Vocational Rehabilitation Service and the "Home Town" program of the Veterans Administration, by the voluntary medical care insurance plans known as Blue Shield plans, and by the Workmen's Compensation programs. It is frequently used by programs of public medical care covering recipients of public assistance and "medically needy" persons and by Crippled Children's programs for the purpose of paying for treatment. Often the fees for the same type of service requiring the same skill and time vary considerably from program to program in the same area.

Payment of flat rates per unit of time or per clinic session is the prevailing method of compensating physicians for service at diagnostic clinics under the Crippled Children's programs and is not uncommon under the other programs of public medical care. Flat rates per eligible persons are paid by some programs of public medical care for the needy, such as that in Baltimore, and by the Health Insurance Plan of Greater New York which makes per capita payments to the group practice units, leaving distribution of the sums to the affiliated physicians.

The part-time salary method is utilized by at least eight state agencies in charge of Crippled Children's programs for the purpose of compensating physicians for a varying combination of diagnostic, consultative, and therapeutic services and by a number of local units of government employing town, city, or county physicians to render home care, office care, or both to needy persons.

Full-time salaries are paid primarily to physicians on the staffs of hospitals operated as centers of medical care programs, such as those of the Veterans Administration and the U. S. Public Health Service, and occasionally to physicians responsible for home, office, clinic, and hospital care, or only some of these types under programs of public medical care for needy persons, as in Buffalo, N. Y., Cincinnati and Cleveland, Ohio, Louisville, Ky., and Sacramento, Calif. Guaranteed annual incomes, comprising a basic salary and additional payments for full-time service, are common under voluntary group-practice prepayment plans.

COMMENTS

If the problem of paying physicians for service in medical care programs is

to be discussed fruitfully, the basic conflict arising out of the conception of "medicine as a profession of a cultivated gentleman" (Sir William Osler) must be clearly and fully realized. As R. H. Tawney has said so well, the meaning of the physician's profession, both for himself and the public, "is not that he makes money but that he makes health." Although he enters the profession for the sake of livelihood, "the measure of his success is the service which he performs, not the gains which he amasses." If the physician lives up to professional ideals and strictly observes the code of ethics embodied in the Hippocratic oath he may well conclude his days in poverty. If he acts like a businessman he can acquire a big bank account and a large estate within a few years but will furnish ample ammunition for complaints about commercialism in the system of private practice. A well organized and efficiently administered system of paying physicians for service in medical care programs can markedly reduce the dilemma confronting the possessor of the most humane of arts.

Experience in the United States with the basic methods of payment permits six broad statements.

1. Missionaries by far outnumber mercenaries among the participating physicians. This very fact testifies to the importance of administrative procedures protecting the honest, conscientious, and careful physicians against those relatively few colleagues who, unintentionally or deliberately, cause serious damage to a medical care program by disregarding established standards of service, ignoring the rules for the operation of the plan, or violating the principles of professional ethics.

2. The payments from both tax-supported and insurance programs to participating physicians have multiplied in the last twenty years. They constitute a steadily growing proportion of the total professional income for a continuously increasing number of physicians in private practice and the sole source of support for more than ten thousand physicians devoting their full time to direct service under public programs. Although some physicians in private practice derive substantial, if not huge, incomes from certain programs, especially insurance plans, the average situation leaves much room for improvement. Fully justified criticism is directed against fee schedules lacking the flexibility so necessary for adjustment of fees to services requiring unusual skill; against flat rates and part-time salaries too low and too limited in range to attract or hold competent physicians; and against full-time salaries insufficient to satisfy specialists or unprotected by tenure.

3. If the countless articles in medical journals reflect opinions correctly, most physicians are concerned more over the rate of payment and the total income than over the form in which they are compensated by a program, provided they are given complete freedom to render service according to their own conviction and to establish and maintain the usual professional relationship with their patients. Almost all programs have adopted specific provisions establishing the principle of professional independence and protecting the patient-doctor relationship.

4. The dollar buys more service, and administration of a program is simpler and more economical, if payment to physicians is made on the basis of the flat-rate or salary methods rather than the fee-for-service method. However, cheap medical care is always costly.

5. To be satisfactory, a system of payment to physicians must encourage adequate service in health and sickness, provide an income related to ability and effort as well as work load, and be easy and inexpensive to administer.

6. No method of payment possesses the magic power of producing high quality of service. Any systematic arrangement for the compensation of physicians must be an integral part of a service organization designed to attain effective teamwork between general physicians and specialists and highest possible standards of medical care.